Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005022	A. BUILDING: _____ B. WING _____	C 11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOSPITAL INC	**1606 N SEVENTH ST TERRE HAUTE, IN 47804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State complaint. Complaint: #IN00133167 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005022 Survey Date: 11/14/13 Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor Union Hospital Inc. is in compliance with 410 IAC 15-1.6.2, Emergency services, Hospital Licensure Rules QA: claughlin 12/04/13	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE